FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0017590

Facility Name: BARRY COMMUNITY CARE CENTER

Address: 1313 PRATT (Number) BARRY (City) 62312 (Zip Code)

County: PIKE

Telephone Number: 217-335-2326 **Fax #** 217-335-7031

IDPA ID Number: 370990780001

Date of Initial License for Current Owners: 1975

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: YVONNE CHUA **Telephone Number:** 636-394-3000

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) JAMES J. GIARDINA

(Title) PRESIDENT

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) DARRYL E. BUEKER, CPA

(Firm Name & Address) BAIRD, KURTZ & DOBSON
PO BOX 1190, SPRINGFIELD, MO 65801-1190

(Telephone) 417-865-8701 Fax # 417-865-0682

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 27816

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	76	Skilled (SNF)	76	27,816	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	76	TOTALS	76	27,816	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,393	913		2,306	8
9	SNF/PED					9
10	ICF	16,641	6,475		23,116	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	18,034	7,388		25,422	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.39%

D. How many bed-hold days during this year were paid by Public Aid? 196 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 2/22/75

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified and days of care provided

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [Y] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	130,181	8,757	5,913	144,851		144,851		144,851			1
2	Food Purchase		124,278		124,278		124,278	(6,126)	118,152			2
3	Housekeeping	74,330	17,033		91,363		91,363	44	91,407			3
4	Laundry	19,600	12,726		32,326		32,326		32,326			4
5	Heat and Other Utilities			64,070	64,070		64,070		64,070			5
6	Maintenance	23,697	26,778	16,316	66,791		66,791	300	67,091			6
7	Other (specify):*											7
8	**TOTAL General Services**	247,808	189,572	86,299	523,679		523,679	(5,782)	517,897			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	748,861	65,002	656	814,519		814,519		814,519			10
10a	Therapy	5,932		5,328	11,260		11,260		11,260			10a
11	Activities	30,128	2,323	2,575	35,026		35,026	1	35,027			11
12	Social Services	14,809		2,200	17,009		17,009		17,009			12
13	Nurse Aide Training			1,596	1,596		1,596		1,596			13
14	Program Transportation											14
15	Other (specify):* Lab Consultant			250	250		250		250			15
16	**TOTAL Health Care and Programs**	799,730	67,325	12,605	879,660		879,660	1	879,661			16
	C. General Administration											
17	Administrative	63,669			63,669		63,669	13,287	76,956			17
18	Directors Fees											18
19	Professional Services			127,890	127,890		127,890	(123,359)	4,531			19
20	Dues, Fees, Subscriptions & Promotions			8,989	8,989		8,989	(3,084)	5,905			20
21	Clerical & General Office Expenses	46,480	7,152	15,603	69,235		69,235	23,120	92,355			21
22	Employee Benefits & Payroll Taxes			144,990	144,990		144,990	3,963	148,953			22
23	Inservice Training & Education			877	877		877		877			23
24	Travel and Seminar			6,231	6,231		6,231	1,811	8,042			24
25	Other Admin. Staff Transportation							21	21			25
26	Insurance-Prop.Liab.Malpractice			20,167	20,167		20,167	221	20,388			26
27	Other (specify):*											27
28	**TOTAL General Administration**	110,149	7,152	324,747	442,048		442,048	(84,020)	358,028			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,157,687	264,049	423,651	1,845,387		1,845,387	(89,801)	1,755,586			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER #0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			47,316	47,316		47,316		47,316			30
31	Amortization of Pre-Op. & Org.			5,785	5,785		5,785	(5,785)				31
32	Interest			105,094	105,094		105,094	(40,201)	64,893			32
33	Real Estate Taxes			36,599	36,599		36,599		36,599			33
34	Rent-Facility & Grounds							4,936	4,936			34
35	Rent-Equipment & Vehicles			6,717	6,717		6,717	1,218	7,935			35
36	Other (specify):*											36
37	**TOTAL Ownership**			201,511	201,511		201,511	(39,832)	161,679			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops			258	258		258		258			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			41,724	41,724		41,724		41,724			42
43	Other (specify):* **Inc Tax Prov**			50	50		50	(50)				43
44	**TOTAL Special Cost Centers**			42,032	42,032		42,032	(50)	41,982			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,157,687	264,049	667,194	2,088,930		2,088,930	(129,683)	1,959,247			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(5,769)	2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(2,684)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(357)	2		13
14	Non-Care Related Interest	(37,517)	32		14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(152)	21		18
19	Entertainment	(25)	24		19
20	Contributions	(766)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(6,820)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(2,137)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(50)	43		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising	(984)	20		28
29	Other-Attach Schedule MISC INCOME	(1,723)	21		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (58,984)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(5,785)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(64,914)	VAR.	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (70,699)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (129,683)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Page 5A

BARRY COMMUNITY CARE CENTER

ID# 0017590

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$ (1,723)	21	1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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42				42
43				43
44				44
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46				46
47				47
48				48
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57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(1,723)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(6,126)	0	0	0	0	0	0	0	0	0	0	(6,126)	2
3	Housekeeping	0	44	0	0	0	0	0	0	0	0	0	44	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	300	0	0	0	0	0	0	0	0	0	300	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(6,126)	344	0	0	0	0	0	0	0	0	0	(5,782)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	1	0	0	0	0	0	0	0	0	0	1	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	1	0	0	0	0	0	0	0	0	0	1	16
	C. General Administration													
17	Administrative	0	13,287	0	0	0	0	0	0	0	0	0	13,287	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(6,820)	(116,539)	0	0	0	0	0	0	0	0	0	(123,359)	19
20	Fees, Subscriptions & Promotions	(3,121)	37	0	0	0	0	0	0	0	0	0	(3,084)	20
21	Clerical & General Office Expenses	(2,641)	25,761	0	0	0	0	0	0	0	0	0	23,120	21
22	Employee Benefits & Payroll Taxes	0	3,963	0	0	0	0	0	0	0	0	0	3,963	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(25)	1,836	0	0	0	0	0	0	0	0	0	1,811	24
25	Other Admin. Staff Transportation	0	21	0	0	0	0	0	0	0	0	0	21	25
26	Insurance-Prop.Liab.Malpractice	0	221	0	0	0	0	0	0	0	0	0	221	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(12,607)	(71,413)	0	0	0	0	0	0	0	0	0	(84,020)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(18,733)	(71,068)	0	0	0	0	0	0	0	0	0	(89,801)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	(5,785)	0	0	0	0	0	0	0	0	0	0	(5,785)	31
32	Interest	(40,201)	0	0	0	0	0	0	0	0	0	0	(40,201)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	4,936	0	0	0	0	0	0	0	0	0	4,936	34
35	Rent-Equipment & Vehicles	0	1,218	0	0	0	0	0	0	0	0	0	1,218	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(45,986)	6,154	0	0	0	0	0	0	0	0	0	(39,832)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(50)	0	0	0	0	0	0	0	0	0	0	(50)	43
44	**TOTAL Special Cost Centers**	(50)	0	0	0	0	0	0	0	0	0	0	(50)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(64,769)	(64,914)	0	0	0	0	0	0	0	0	0	(129,683)	45

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
JAMES J. GIARDINA	100	MAR-KA NURSING HOME	MASCOUTAH	COMMUNITY CARE	BALLWIN, MO	HOME OFFICE
		WEST MAIN NURSING HOME	MASCOUTAH	CENTERS, INC.		
		MONMOUTH NURSING HOME	MONMOUTH			

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	19	HOME OFFICE	$ 117,440	COMMUNITY CARE CENTER, INC.	COMMON	$ 52,526	$ (64,914)	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 117,440			$ 52,526	$ * (64,914)	14

*** Total must agree with the amount recorded on line 34 of Schedule VI.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week: Hours	Percent	Compensation Included in Costs for this Reporting Period**: Description	Amount	Schedule V. Line & Column Reference	
1	JAMES J. GIARDINA	PRESIDENT	GEN. DIRECTOR	100.00	NONE	3	4.26	SALARY	$ 11,509	17.7	1
2	DOROTHY GIARDINA	VICE PRES/SEC		0.00	NONE	1	2.50	SALARY	1,778	17.7	2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 13,287		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: COMMUNITY CARE CENTERS, INC.
Street Address: 312 SOLLEY DRIVE-REAR
City / State / Zip Code: BALLWIN, MO 63021
Phone Number: (636) 394-3000
Fax Number: (636) 394-7713

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	HOME OFFICE	DIRECT COST			$	$		$	1
2		WEST COUNTY CARE CTR						4,058,105	210,661	2
3		ST GENEVIEVE CARE CTR						1,815,682	94,255	3
4		CCC OF LEMAY						1,861,179	96,615	4
5		SALEM CARE CENTER						1,503,096	78,028	5
6		MONMOUTH NH						1,418,448	73,634	6
7		MAR-KA NH						1,981,823	102,878	7
8		WEST MAIN NH						906,323	47,049	8
9		CCC OF SENECA						2,243,581	116,468	9
10		MT VERNON PLACE CARE						2,126,851	110,409	10
11		COUNTRY VIEW NH						1,841,678	95,604	11
12		MERAMEC NH						1,743,248	90,493	12
13		SEVILLE CARE CENTER						1,969,138	102,221	13
14		SALEM RES. CARE						416,466	21,619	14
15		BOSS RES. CARE						110,788	5,750	15
16		CARL JUNCTION RES. CARE						514,891	26,729	16
17		MT VERNON RES. CARE						304,963	15,831	17
18		SENECA HOME PLACE						391,561	20,327	18
19		HUDSON HOUSE						389,647	20,227	19
20		MAPLE GROVE LODGE						1,984,236	103,005	20
21		SMITH BARR MANOR						1,333,076	69,202	21
22		CCC OF AURORA						3,339,388	173,351	22
23		BARRY COMMUNITY CARE						1,011,857	52,526	23
24		COMMUNITY IN HOME						290,180	15,064	24
25	TOTALS					$	$		$ 1,741,946	25

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	FIRST NAT'L BANK OF BARRY		X	MORTGAGE/2ND MORT	$6,734.88	2/94, 9/98	$ 752,000	$	3/01/04	7.5-8.5%	$ 1,349	1
2	FIRST NAT'L BANK OF BARRY		X	MORTGAGE	$8,049.29	1/13/00	962,000	836,599	1/13/07	8.0000	64,665	2
3												3
4												4
5												5
	Working Capital											
6	LEASES		X	VARIOUS LEASES	VARIOUS	VARIOUS	6,541		VARIOUS	VARIOUS	1,563	6
7												7
8												8
9	TOTAL Facility Related				$14,784.17		$ 1,720,541	$ 836,599			$ 67,577	9
	B. Non-Facility Related*											
10	UNION PLANTERS BANK		X	STOCK BUYOUT	$3,438.87	5/24/00	400,000	394,979	5/24/05	8.2500	19,052	10
11	JOHN HUBBARD	X		STOCK BUYOUT	$3,870.35	5/24/00	319,000	306,547	5/24/10	8.0000	14,640	11
12	MARK HUBBARD	X		REDEMPTION OF SHARES	$3,588.88	2/01/95	461,482		12/16/14	8.2500	3,825	12
13												13
14	TOTAL Non-Facility Related				$10,898.10		$ 1,180,482	$ 701,526			$ 37,517	14
15	TOTALS (line 9+line14)						$ 2,901,023	$ 1,538,125			$ 105,094	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	32,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	34,631	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,831	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	34,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(32)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	36,599	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	25,654	8
	1996	24,653	9
	1997	28,568	10
	1998	32,788	11
	1999	34,631	12

ACCRUAL - 1999 TAXES 34,631 / 12 MOS = 2,886 ROUND TO 2,900 X 12 = 34,800

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 28,930 B. General Construction Type: Exterior BRICK Frame STEEL Number of Stories ONE

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	5.04 ACRES	1973	$ 20,739	1
2					2
3	TOTALS	5.04 ACRES		$ 20,739	3

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	76		Feb-75	1975	$ 805,055	$ 26,836	30	$ 26,836	$	$ 688,642	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PATIO			1976	936					936	9
10	DRIVE			1987	3,002	95		95		1,276	10
11	ROOF			Apr-95	27,030	1,802		1,802		10,362	11
12	BLACKTOP DRIVE			1998	6,300	420		420		978	12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 842,323	$ 29,153		$ 29,153	$	$ 702,194	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 128,917	$ 15,488	$ 15,488	$	5-7 yr	$ 90,114	37
38	Current Year Purchases	34,122	2,675	2,675		3-10 yr	2,675	38
39	Fully Depreciated Assets	64,817					64,817	39
40								40
41	TOTALS	$ 227,856	$ 18,163	$ 18,163	$		$ 157,606	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43	N/A									43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,090,918	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 47,316	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 47,316	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 859,800	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53	N/A				53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59	N/A		59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 6,717 Description: COPIERS 2,594; LIFTS 2,512; ICE MACH 425; GAS TANK 50; STEAM COOKER 1,136
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [X]
- HOURS PER AIDE 80

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE 40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$ 1,446	$	$ 1,446
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		150		150
9	TOTALS	$	$ 1,596	$	$ 1,596
10	SUM OF line 9, col. 1 and 2 (e)	$ 1,596			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	3
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	3

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist	N/A	hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 142,801	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	180,320		3
4	Supply Inventory (priced at COST)	2,050		4
5	Short-Term Investments			5
6	Prepaid Insurance	8,643		6
7	Other Prepaid Expenses	31,122		7
8	Accounts Receivable (owners or related parties)	702,136		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,067,072	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	20,739		13
14	Buildings, at Historical Cost	842,323		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	227,856		16
17	Accumulated Depreciation (book methods)	(854,799)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	53,884		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(5,785)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): DEPOSITS	1,000		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 285,218	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,352,290	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 181,720	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	67,740		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,921		31
32	Accrued Real Estate Taxes(Sch.IX-B)	34,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	DUE TO RELATED PARTY	15,376		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 304,557	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	701,526		39
40	Mortgage Payable	836,599		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	NON-COMPETE N/P	31,500		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,569,625	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,874,182	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (521,892)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,352,290	$	48

***(See instructions.)**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (624,731)	1
2	Restatements (describe):		2
3	N/P CONSOLIDATION - SALE OF STOCK	96,929	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (527,802)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	5,910	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 5,910	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (521,892)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,045,132	1
2	Discounts and Allowances for all Levels	(1,478)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,043,654	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	650	6
7	Oxygen	12,318	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 12,968	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	9,383	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	17,773	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 27,156	23
	D. Non-Operating Revenue		
24	Contributions	449	24
25	Interest and Other Investment Income***	2,684	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 3,133	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING MACHINE INCOME	5,769	28
28a	MISC INC $1,723; N.A. TRAINING REIMB $437	2,160	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 7,929	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,094,840	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	523,679	31
32	Health Care	879,660	32
33	General Administration	442,048	33
	B. Capital Expense		
34	Ownership	201,511	34
	C. Ancillary Expense		
35	Special Cost Centers	258	35
36	Provider Participation Fee	41,724	36
	D. Other Expenses (specify):		
37	INC TAX PROVISION	50	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,088,930	40
41	**Income before Income Taxes (line 30 minus line 40)****	5,910	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 5,910	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,167	2,183	$ 42,269	$ 19.36	1
2	Assistant Director of Nursing					2
3	Registered Nurses	9,751	10,246	184,323	17.99	3
4	Licensed Practical Nurses	9,432	9,765	107,696	11.03	4
5	Nurse Aides & Orderlies	51,095	51,271	395,883	7.72	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	562	562	5,932	10.56	8
9	Activity Director	1,760	1,826	14,685	8.04	9
10	Activity Assistants	2,196	2,335	15,443	6.61	10
11	Social Service Workers	1,966	2,030	14,809	7.30	11
12	Dietician					12
13	Food Service Supervisor	2,195	2,219	19,965	9.00	13
14	Head Cook					14
15	Cook Helpers/Assistants	9,935	10,427	70,307	6.74	15
16	Dishwashers	6,230	6,504	39,909	6.14	16
17	Maintenance Workers	2,210	2,235	23,697	10.60	17
18	Housekeepers	10,606	11,145	74,330	6.67	18
19	Laundry	2,766	2,942	19,600	6.66	19
20	Administrator	3,033	3,057	63,669	20.83	20
21	Assistant Administrator					21
22	Other Administrative	5,652	5,792	46,480	8.02	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,408	2,504	18,690	7.46	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	123,964	127,043	$ 1,157,687 *	$ 9.11	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	204	$ 5,913	1.3	35
36	Medical Director				36
37	Medical Records Consultant	5	200	10.3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	24	456	10.3	39
40	Physical Therapy Consultant	360	5,328	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	38	2,491	11.3	44
45	Social Service Consultant	38	2,200	12.3	45
46	Other(specify) Lab Consultant	9	251	15.3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	678	$ 16,839		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
DOUG MILLS	ADMINISTRATOR	0	$ 63,669
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 63,669

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
COMMUNITY CARE	MANAGEMENT	$
CENTERS, INC	FEES	117,440
ARNOLD, BEHRENS, DETER		
& GRAY, PC	ACCOUNTING	3,630
ROSENBLUM, GOLDENHIRSCH	LEGAL	6,820
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 127,890

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 26,578
Unemployment Compensation Insurance	
FICA Taxes	97,442
Employee Health Insurance	5,470
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
VACATION PAY	4,857
OTHER EMPLOYEE BENEFITS	10,643
HOME OFFICE ALLOCATION	3,963
TOTAL (agree to Schedule V, line 22, col.8)	$ 148,953

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
NONE		
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	681
Health Care Worker Background Check	
(Indicate # of checks performed 5)	60
ADVERTISING OTHER	3,121
DUES & SUBSCRIPTIONS	4,289
TAXES & LICENSES	838
HOME OFFICE ALLOCATION	37
Less: Public Relations Expense	( )
Non-allowable advertising	(2,137)
Yellow page advertising	(984)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 5,905

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,096
MEALS	25
Seminar Expense	2,110
	1,836
Entertainment Expense	(25)
TOTAL (agree to Sch. V, line 24, col. 8)	$ 8,042

**See instructions.

Facility Name & ID Number BARRY COMMUNITY CARE CENTER # 0017590 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3			N/A										
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BARRY COMMUNITY CARE CENTER **#** 0017590 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **IL HEALTH CARE ASSOC - '$3,067**

(3) Did the nursing home make political contributions or payments to a political action organization? **YES** If YES, have these costs been properly adjusted out of the cost report? **YES**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **7 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **9,727** Line **10.2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,724**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **N/A** Indicate the amount. $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **8%**
d. Have vehicle usage logs been maintained? **YES**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **N/A**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.